Health Reform Framed Around Three Draft Messages

1. Providing and Protecting Affordable Health Insurance

	At-Large Council
Benefits Package	• Along with major medical, I think prescription and basic dental are the most important items for a health plan. I would be loathed to cut anything because it can all be very important to someone, however, if pushed into cutting something to reduce costs, I would cut vision and mental health coverage. The cost of an eye exam and corrective lenses is generally a small one time expense every year or two and mental health coverage is only used by a small percentage of patients. Would a subsidized à la carte plan based on income be a consideration? • If you take a look at medical cards, some people have decided in Kansas dental benefits are a "luxury for the poor". Whatever the reasons, I assume they would also apply here. Again, there is not "parity" for the poor in mental health coverage. I assume the same reasons would apply here. I am a consumer, but, you need to START somewhere. • Major medical, Rx and dental are the three benefits that need to be included in basic coverage. There has been a lot written recently as to the impact dental care has on one's health. I think not to include this would be a problem. A medical plan without an Rx benefit will likely be more costly since when people need to prioritize their spending Rx is something many view as something they can live without, which in many cases just ends up costing our health care system more in the long run. I do not support an ala carte system as has been suggested since adverse selection is always present when people get to design their own benefits. It is difficult if not impossible to spread the risks over a large population when the population gets to pick and choose their benefit design. • Benefits should include eye and teeth, as well as mental health. We are a whole body; neither the eye nor the mind operates separate from the rest of the body. I believe we need to ensure everyone has accessible and affordable health care coverage and that coverage should promote and maintain the optimal level of health, thus in the long range, be cost neutral, even cost effective. I do believe plans should be flexible enough to accommodate different care needs but I also believe what is good for one person's health is also good for another's. I liked the idea that someone shared with the group at our meeting in May about having the insurance companies invest back into the beneficiaries. I support insurance companies being required to invest a percentage of their earnings back into the beneficiaries in the way of health promotion and prevention. I believe that all benefit plans should include one free health maintenance visit a year to ensure communication of what the doctor expects the person to do to maintain good health and what the person has been experiencing in the way of eye sight and other things that at first glance can seem uneventful and unrelated to other health care but left unattended to can be more detrimental to the person's over all health. I would think insurance companies would like this idea in that the annual maintenance visit could be used to establish a standard

	contract between the primary care physician (PCP) and the insured that lists what the recommendations are for good health maintenance and what referrals are further needed to ensure the person gets the information and training needed to improve their health management skills. This could be as simple as a plan of care (POC,) e.g. quit smoking and increase physical activity. The POC would then be signed and dated turning it into an executed contract between the doctor and the beneficiary making the burden of appropriate healthcare choices both the beneficiary's responsibility as the physician's to educate and support. For instance, if a person, of sound mind, chooses to smoke, after the doctor and the person have signed the POC stating the doctor is recommending to quit smoking and has discussed potential supports available to the beneficiary and that continued smoking will put them at greater risk of things such as poor skin condition, lung diseases and even cancer, and the individual chooses to continue smoking, this should be documented on the POC. Why would we want to support paying the same rate of coverage for the non-compliant individual's emphysema or cancer treatment when they willingly chose to neglect good medical advice? On the other hand, if a beneficiary has made appropriate choices, consults with the doctor these choices and others available and still has to battle that type of chronic or fatal disease, they should get it at a coverage that will not cause them to go bankrupt! I am all for equal coverage for everyone but I do not want to pay taxes and benefits out for individuals who willingly chooses to make poor health care choices while at the same time, I do not want to see anymore of us lower-middle class folks get turned over to collection agencies for unrealistic health care monthly payments that turn into one month's missed payment going over to collection agencies. I'm not trying to sound cold, pessimistic or jaded; I'm trying to be realistic in the responsibility and accountability areas of where my tax dollars go and how I can actually help support the health care system to support itself. I think until we make sure the system supports the co-responsibility of learning how to manage our own health, we should not be limiting benefit packages based on "typical" packages. I hope that in getting everyone affordable and accessible insurance we are also looking at what the system is doing to support a healthier society and less reliance on government funding to provide adequate healthcare coverage. I think we need to build health care systems that identify natural partnerships and then make sure supports are in place that will help it depend on itself instead of more taxes, less benefits and not everyone taking responsibility for their individual role in a good health care system. • Every Kansan should have the same benefits as members of the US Senate and US House of Representatives have. They are covered by the Federal Employee Benefits Plan. Several years ago Pitney Bowes divided employees with asthma into two groups- one group had a zero deductible and no co-pays; the second group had traditional deductibles and co-pays. Contrary to expectation, after a year, the group with no-co pays and no deductibles had lower health care expenses - simply because these employees sought early intervention for their asthma rather than wait until they where very sick and would require more costly intervention. Recently, Safeway announced that by giving its employees a plan with zero deductibles and co-pays, it has been able to keep its insurance premium for next year the same as this year, i.e., no increase. The take home message is that a comprehensive program of universal insurance with minimal or no co-pays and deductibles - may in the long run save the health care system money.

- I think the idea of not paying for someone's care if they do not choose to live a healthy life style is an interesting concept but what happens when they show up in hospital emergency departments, they have to be seen and treated. Thus, what really happens is that everyone with insurance or who pays privately ends up paying for these irresponsible individuals. A significant legal and cultural shift would have to take place in our society in order for this concept to work.
  I support the idea of developing a healthy life-style plan with your physician and monitoring progress toward the plan on an annual basis or at least allowing that to be part of the standard benefit design.

- It is always difficult to pick and choose what benefits are the most important- while mental health is used by only a few people, it is often a crucial need for those few. If I really need to have a "bare bones" plan, I would include prescription drug coverage, major medical, and procedures. I think we could do without dental, or vision, but I would like to include them. I think there should be incentives for cost-saving, such as the use of more inexpensive medications when possible (generics or lower cost trade-name drugs). The most effective way to do this is probably with tiered co-pays.
  I like the idea of a least one free visit per year, and additionally free routine screening, such as yearly pap smears and mammograms, but I don't think people should be penalized for their life-style choices. It becomes very difficult to decide where we stop that, do we insist that someone who is homosexual or promiscuous pay more? How about someone who is obese? Someone who eats too much meat or too much fat? How about alcohol?
  At some point, choices may need to be made about coverage of high risk, high cost, low yield procedures and medications.

- I had not considered "other" life style choices that could be perceived as health related activity and would definitely not support this type of judgmental approach.
  I just want to see us provide affordable plans that make a difference in our overall health maintenance and start putting each of us in the accountability/responsibility role. The working poor I've talked to state that even if there was a policy, they probably couldn't afford the premiums or the co-pays. If we're already looking at benefits to cut from plans, such as eyes and teeth, so it's affordable, are we really looking at the group of individuals we're trying to cover and what their actual needs are? How are we supporting the need for a new approach in our health care system and the need to have people be able to do preventative and maintenance type of activities to improve or maintain good health, if that isn't part of the benefits?
  Is it possible that the individual could have their annual health care assessment/evaluation and then have the option to develop their benefit package? If so, then I could see limiting benefits. I'm hoping to see benefits developed that empower beneficiaries to be the driver of their own health care planning. I look forward to hearing ideas on how we can provide affordable and accessible health care insurance, while making sure we're not just throwing more money at a system that may need to re-evaluate its role in how health care is administered and received.

- Some have suggested basing premiums on lifestyle. First, the administration of and enforcement of this would be incredibly complex and costly. Second, as stated by others, the potential for lawsuits would be enormous. Third, this simply can't be done

within the confines of current law. HIPAA and ADA restrict this type of behavior.

- It should be fairly obvious that we will not be able to provide more healthcare services to more people for less money. It also follows that our ability to raise enough money from all means will not be sufficient to cover the costs of all services for all people. At some point, rationing may have to happen at the high end of the healthcare services spectrum to be able to fund the normal, routine, preventive, lower cost services. Rationing can occur by reduced availability (as in most countries with a nationalized health care system), by reducing heroic measures at end of life, by eliminating from eligibility those whose lifestyle recklessly consumes resources, by limiting transplants, and so on. Rationing of a sort may already be upon us due to chronic and increasing shortages of physicians, nurses, and other health professionals.
  I don't support rationing, but the economic realities force us to have the discussion.

- America has a long history of taking care of our needy citizens, starting with the Pilgrims who had an enforced “tithing” plan to provide for them. We will always require that someone in medical need be cared for at an ER at some level, and who of us would want to turn away a suffering person, even if their suffering is largely their own fault due to poor choices? Of course we all know that ER care is way more expensive than if the problem had been nipped in the bud at a clinic or Dr's office. Therefore, what makes the most sense is UNIVERSAL COVERAGE, by "individual mandate" if necessary, through a system of health clinics for routine care, including preventive. Because this is America there would be private clinics for those who think they need a more elite level of care, but everyone should be able to walk in and get medical attention for the most common medical ailments. I like the annual check-up and personal health plan idea, perhaps employers could give incentives to those who do this and/or there could be a small tax incentive. Another idea would be traveling "Check-up vans" that would bring the clinic to the workplace, this would help small businesses who can't afford an in-house clinic like some big companies have.
  As for specific benefits, as a Clinical Social Worker I must advocate for mental health coverage. Study after study has demonstrated the connection between mental and physical health, you can't separate them and provide effective care. I am required to communicate with my clients' physicians (unless they waive that right) because of this reality: their symptoms could have a medical basis, or visa versa. There has been federal legislation on the table this year to require parity of mental and medical coverage’s, and there was a bill considered in Kansas, so I don't think we can avoid including mental health. Screenings for depression, anxiety, etc. could become a part of that annual check-up, which would end up saving a lot of money by providing early treatment before these illnesses become debilitating and cost much more to treat. Rather than trying to figure out what to exclude, I think we should be looking for more efficient ways to provide all the basic care Kansans need.

- Standardizing the benefits package for all Kansans, whether self-employed, state employed, small or large company should be the first step at decreasing costs. I have read opinions of many involved in health care, but it seems that we are missing the point. The cost of health care is a stumbling block, but where would be a place to start decreasing costs? Could decreasing overhead for providing health care be a legitimate starting place?
  Standardizing health insurance policies would allow providers to file claims in a timelier manner with the assurance that payment

	would be forthcoming. I listened to a presentation last Sunday, and the thing that I got from this was that 30% of all claims are rejected on the first try and 15% of these claims are never paid. This increases providers' overhead expenses, by extending the process to get paid but also with the lost money that is never paid. I am not advocating that government provide health insurance, but they should provide the types of health insurance that can be purchased. After dealing with Medicare Part D for 18 months and trying to comply with all the new regulations to prevent fraud, waste and abuse, I know for sure that government should not be in the insurance business. Government should act as a watch-dog over the insurance industry to maintain that all of its citizens are treated equally. Prompt payment of claims would also help providers to decrease overhead costs. In pharmacies, we use real time adjudication of claims, but it still takes 30-45 days to receive payment. The payers claim this is the industry standard. It is one standard that needs changed. Asking anyone out there who is a provider, "How much less could you take for a procedure, office call, stay in hospital, PT session, etc. if you could get reimbursed within 48 hours?" Think about it, if the banking industry can move money electronically, the insurance industry could do the same thing. Real time claim adjudication for all health care professionals is a must along with prompt payment. • Mental health is an essential benefit that must be covered under any benefits package. Research continues to confirm that mental health and physical health are tied together. It also shows that when persons are provided access to covered mental health benefits, the corresponding physical health care expenditures go down. This is a must in my view. If we don't then we just shift the burden to the public sector, which continues to be stretched. • Having a limited number of benefit plans makes sense. Having simpler plans has appeal to everyone. However, these will have a minor impact on health care costs. For example, assume all benefits are subject to a $250 deductible and 80% coinsurance to a certain out-of-pocket limit. What encouragement is there for an individual to use less costly medications? Once they have satisfied their deductible/OOP, what restraint is built in to the system to slow down unnecessary use of health care services?
Small Businesses	• I think it is important to open the incentives to all small businesses. That is a business of less than 50 employees. Incentives to provide insurance or participate in a state assisted plan could be based on the tax bracket of the business. The incentives could take the form of tax relief to the business based on income. I feel the number one issue to small business is cost of the plan. The smaller the number of persons in a group, the tougher it is to get an affordable plan. • If we do this, it should be optional for all "small" businesses. As far as to what to include and/or exclude, there should be a menu of options to choose from. The cost should be a tax deduction as an incentive to participate. Also, the employees should shoulder some responsibility of the cost, to give them some personal value for what they are receiving. The insurance companies licensed in Kansas should help in this effort, by premium deductions. Presently these plans only provide an additional windfall for these

	health insurance companies, the only sector of the healthcare industry that makes huge profits. • I think ALL small businesses should be offered the opportunity. This will increase the size of the "group" making coverage better for everyone. The key here for small businesses is to offer any kind of "real" coverage, not just catastrophic coverage, at a cost their tight budgets can cover. • I think that whatever incentives are offered should be given to all (I assume small business is 50 or fewer) otherwise what incentive is there to continue to offer insurance? I realize the question is stated as limiting the incentive to those small businesses who have never offered insurance, but what about a company that has not offered it for the past two years due to the cost? Should they not get the incentive to offer insurance again? What about the business that dropped it last year for the same reason? Where would you cut this off? It seems to me that the fair thing to do is offer the incentive to all, thus it is an incentive to continue to insure as well as to begin to insure. I think the biggest obstacle for small business is the cost of insurance. • I agree that the major problem with access is cost of insurance. Often, when insurance is being written for a small company, one high risk individual can increase the premiums tremendously. This also means that small businesses are likely to avoid hiring people with disabilities or other pre-existing medical problems. I agree that any incentives should be given to any business with under 50 people. Penalizing those who have already been providing insurance would be unfair. I also wish to point out that the real problem is not cost of insurance, but cost of health care. Until we can figure out how to rein in health care cost, we are just putting a band-aid on the problem. • There are a significant number of small, not-for-profit organizations in Kansas that are not able to provide GHI for their employees. As we think about incentives keep in mind the various energy tax credit proposals. Many of them allow the transfer of these credits. The sale of tax credits by non-profits with no tax liability to for-profit entities with tax liabilities [potentially at a less than face value discount] will create financial incentives for both. • For many small Kansas businesses a large increase in costs would put the business out of business. Not only would that not provide health care for the workers it would take away their jobs. On the other hand, with minimum wage going up, many employers are looking for ways to cut employees. If you cut off participation at 25 employees the state may see a large increase in 24 employee companies.
Employer Responsibility	• It should be like an employee "health tithe" -- 10% of the organization's gross should go toward a "match" of the employee's health insurance costs. If more than 25 people are employed, no exceptions. BUT, if less than 25 employees, it should be optional for the business to choose.

	• I think employers should be required to contribute, and I think it should be essentially one big policy for all small businesses so that all can get the benefits of a large company. (You could have a choice of 3 or 4 large health care plans that a company can choose). With this model, I think you could have participation for all small business, rather than carving out the really small businesses as an exception. I think anything more than 10% would be onerous to the businesses, and if we could get away with less, we should. • All employers should be included, large and small. If they contribute to their employee's premium, that amount should be tax deductible. To get participation to the maximum, there must be worthy incentives. Also, the consumer, whether it be the employer or the employee, must see clearly upfront the benefits of a healthy employee, by purchasing packages that encourage regular check ups for preventative medicine. A healthier employee has less work hours lost, is more productive, and is more indebted to the company. • All employers should be required to participate. By allowing those that employ less than 25 to opt out we would be giving a significant number of employers that option. • This is such a tough question with seemingly no easy answer. Even a 10% addition to many employers will be impossible and could put them out of business. It is true they could gain from covering their employees -- lower turnover, healthier employees, increased productivity -- however, these improvements are slow to show up while the cost of the program shows up immediately. Small employers will be particularly hard hit, as the vast majority of large employers already provide coverage. Please note that many employers currently providing coverage could actually see a reduction in their costs if a 10% contribution was required. This could result in these employers dropping their existing plans. If the new employer and employee contribution aren't enough to cover the cost of the program, it will have to be subsidized from some other source (i.e., taxes). If those employers providing coverage decide to drop their current plans, it could result in even higher subsidies being required. • I do not believe employers should be required to contribute to provide health care for all. I believe employers should be weaned off of being responsible for providing health care in this country. Many of the problems that exist today in health care were created when employers and not individuals became the purchaser of health care. Employers began paying for health care in World War II only because the county was under a price and wage freeze and benefits were a way of getting around the wage freeze. Why should employers be responsible for providing health care in this country? Because that is the way we have always done it, is never a good answer. Truly health care should be available for everyone. I would favor an income tax incentive for people to purchase their own health insurance and an income tax that would provide a pool for insurance for those who can not afford insurance. Yes, I realize the devil is in the details and there are a lot of hurdles, but I see no logical reason why employers should not be the providers of health care in this country other than historically that is how we have done it.

	• Gross revenue of any particular company may have little or no bearing on the cost of the health insurance for its employees. For example, 10% of the gross revenue of Boeing may be far more than necessary to provide basic coverage insurance for all its employees. Other companies may only have a 2% net income and if you hit it with a bill of 10% of gross, it immediately becomes an unprofitable enterprise. If it can't raise its charges and recoup, it is out of business. Would governmental entities (state and local) be exempt? If not, their extra costs will be borne by the taxpayer. At some point, all extra cost is typically shouldered by the consumer and/or taxpayer. • I do not think a percentage of gross revenue would work because of the differences in companies. Two small businesses with 6 employees each, one in agricultural and one in technical arenas could have drastically different gross revenues. I would like to see what a formula based on each employee would look like, if that can be done. I do not think it is fair to assess a company more because of its success. If we allow business to opt out, we have defeated the purpose and intent of what we are trying to do, as we would still be faced with uninsured workers. I think we are trying to find a way to insure the working uninsured. Maybe we should look only at businesses of 25 or less employees.
Individual Responsibility& Affordability	• An "affordable plan" is one that ties up LESS than 20% of your gross salary. A plan you can find on the market that covers anything at all will surely cost you 5% of your gross salary unless you earn in the 5 digit salary range. $100 a month is probably a good target. • I think about 5% of gross salary should be an upper limit of any mandatory plan, with possible options with better coverage that might be higher. If we used 10% in employer contributions and 10% in employee contributions, we are looking at about 20% of the national income being used for health care. This seems excessive to me. I don't want to spend 20% of my income, direct or indirect, for health care, and at this point in my life, I never have (nor do I think I should have). • If you accept the 20% target as valid, the minimum premium for a full time employee making minimum wage would be ($5.85 x 2080)x.2 = $202 per month. When minimum wage hits $7.25 in the summer of 2009 it would be $251. • Here's the problem. The nation as a whole is irresponsible in terms of health care. There was a good program, a rerun I think, on "60 Minutes" tonight. It pointed out that the Medicaid Part D bill was a creature wrought and lobbied by and for the pharmaceutical industry. It was passed by five votes after the longest roll call in the history of congress (almost 3 hours, vs. the normal 15 minutes). Republican members were threatened with extreme retaliation if they didn't support it. Drug prices are so out of control, they can't be contained by anything done before 1/21/09 when this administration exits. Bush vetoed the new bill that would have removed the restrictions on Medicare that prohibits it from negotiating drug prices, thanks to PhRMA's (the

pharmaceutical industry's lobby) contributions to his many campaigns. The industry has something like 1,200 lobbyists in D.C. They make a lot of money to keep us from getting affordable health care.
I appreciate the numbers posted, but the Kansas minimum wage is $2.65 hourly. There are 19,000 Kansans who were legally earning less than the Federal minimum when it was the just-revised $5.15/hr.
Now here's another number with which to grapple. When you talk about "affordable" health care and use the # 20%, for a minimum wage worker (the federal rate), how much of that person's income do you think is actually "disposable" after rent, utilities, food, clothing, transportation etc. costs are accounted for? Has anyone on this list (besides me) ever been recently receiving monthly income below the poverty level?
The federal poverty guidelines for the lower 48 states are $13,690 for a family of two (ours). That's exactly what the federal minimum wage will be a year from now (it went up to $5.85 on Wednesday).
There is no such thing as "affordable" health care in America for uninsured working class people. We need universal health care and we need it ASAP.

- Most plans are very high. Most working people can not afford a plan on what they make.
Let's look at a single woman with two children (ages 3, 6) and limited or no child support. If she is lucky, she will have a good job that pays $13.00 an hour and net of about $1700.00 per month.
On that pay she has:
$600 rent
$150 utilities
$400 child care
$400 food & misc
$100 for a cheep undependable car
$70 fuel
$179 health insurance ($5000 deductible, 20%copay, $15 OV)
and more.....
If you do the quick math, you see that she makes too much money for assistance programs, and not enough to pay for her other expenses. Her health policy is 8% of her income....
Is 5% too much to ask or not enough? Every case is different but I think this is a good average example of the people we are worried about.

- Good numbers. But your (only barely) hypothetical single mom, if she has a $5,000 deductible policy, is wasting her money on health insurance. Where is she going to get the money to pay the $5,000? That's a quarter of her annual take home and you didn't count other expenses such as insurance and gas for her beater auto. She's better off sending the kid for needed medical care, putting it all on the cuff and then filing for bankruptcy. That last is a bit harder, because again our friend Tiahrt voted with his caucus to make bankruptcy much more difficult to successfully proceed with, for poor people, even for soldiers serving in Iraq (it

	exempted the mansions of the rich from seizure in states such as Florida). Most of the bankruptcy claims in the U.S. were already the result of un-payable medical bills. • Bankruptcy is what we need to avoid. When I made the list of expenses, it was clear to me that this hypnotically working family would never be able to afford the health insurance policy. The policy was much cheaper because the deductible was so high. So, how do we help her employer offer a plan that both she and the employer can afford? If we require participation in a plan state wide, do we do it as a tax on every business? If we require all employers to participate in a plan, is it only for certain size businesses? 1-30 employees? I would want my hypothetical person to be able to maintain her dignity by keeping her job and I want her employer to be able to stay in business. • Personal responsibility makes sense, however, it is much easier said than done. The old adage "if you build it, they will come" doesn't pertain too many when it comes to their health. You don't have to look far for examples. People know that obesity is terrible for them, yet nearly 30% of our population now fits into this category. The surgeon general began requiring warnings against smoking in the early 60s. We have all seen someone suffering the long term effects of smoking. The countless lawsuits clearly demonstrate the problem here. Yet, we still have millions of people who smoke.
Health Insurance Connector	• No responses were given by the at-large council with regards to this question.
Mandates – Individual & Employer	• Mandates turn people off, especially if they are tired of big government. A more gentle persuasion would be to encourage each adult and/or family-head to in some way buy into the system. Then they have an investment that they will better take advantage. Giving them too much creates less interest. Ideally, businesses should be encouraged to participate in funding their employee's health insurance through tax credits and programs that encourage preventive medicine. Health insurance premiums paid by the individual could be off-set by tax credits as well. • I do not feel that all Kansans have the ability to pay for health insurance. Those who are able should certainly pay what they are able. I think that most Kansans have enough pride to want to pay their way, but many lack the means. A graduated scale would have to be use based on income, dependents, etc. I would hate to put another tax on businesses. Any mandated fee would be a defacto tax. I believe many small businesses are in the same spot individuals are; they have the will but not the means. Preset mandatory assessments would bankrupt many small businesses. Again a graduated system based on net profits and number of employees. • If all Kansans are required to buy health insurance, what is the difference between that and state health care like England, except we have now built in the additional costs of the profits for the health insurance industry and multiplied the paperwork! I think companies smaller than 25 employees should be able to CHOOSE to buy into whatever health care system, but have no

mandates.
That should weed out the companies with the tightest budgets, from being harmed.

- Maybe if we try a two fold approach: the individual's plan doesn't cost more than a percentage of their earnings and that plan includes a free annual check-up; $5 prescriptions and very minimal office visits, no more than $20/visit; and the plans would be based on the business' size and % of income, e.g. a business with 5 and under at an annual income of $250,000/year or less would only pay X% of the plan, then 10 and under at an annual income of $500,000 and so forth...Buy in is only going to happen if, from the onset, we take the approach that the benefits of health care and health maintenance are realized at the business and individual levels with improved attendance; improved productivity; improved quality of life and decreased health care costs.
Won't mandates require looking at the current tax system in order to see what % of each tax is actually used towards what it was originally intended for in order to see where new tax could come from or where it could be shifted from?

- A mandate might indeed be necessary, and legislators may indeed, not have the stomach for mandates. However, if they could go to the voters with some assurances that the health plans would be held accountable and not permitted windfall profits, it might be an easier sell. What I mean to say is this: Any taxpayer subsidization of health insurance premiums, translates into a huge unearned benefit to health plans. They have a whole new base of customers partially financed by taxpayers. When you add a mandate, meaning that the State will now force every citizen to buy the health plan product (and subsidize it), the result is going to be windfall profits.

  If we put a statutory minimum on the medical loss ratio (the percentage of premium dollars that actually go to providing care as opposed to say marketing, executive salaries, administrative costs, and profits), then perhaps the taxpayers could have some assurance that rates will not continue to skyrocket, and providers can have some assurance that they will be fairly reimbursed. Medicare operates on 3% overhead. Most commercial plans fall between 18 and 30% overhead. There seems to be plenty of fat to trim here.

- My questions, "Would it not be of an advantage as a doctor to know that you will be paid at the point of service? Would it not be beneficial to consolidate all coverage's into a small number of plans where the benefits are known?" Confusion reigns in health care. As long as the payors can keep the providers confused and at bay the less money they have to pay out. The other problem with getting insurance companies to cover a routine yearly physical in my opinion is that these entities are great procrastinators. They weigh their chances of having to pay out big bucks against paying for preventative services all the while knowing that maybe they can put off today what can be done next year and maybe next year the poor risk patient will be with another company. While mandates may be unpleasant for the insurance industry, others involved with health care face government mandates on a daily basis. We have mandates in pharmacy regarding dispensing of controlled substances, mandates on how much we will be paid, mandates on bidding for DME business, mandates on use of tamper proof prescription blanks for Medicaid patients, Etc. If the government will place guidelines for health care coverage and the police these guidelines, I think the system has a chance of

	surviving. If we continue to wallow around in poor health care mud we currently have fallen into, the system will eventually fail. The government as a payor is not a good scenario, but as a police officer to monitor the system and correct problems the system might have a better chance of survival.
Revenue Streams	• Tobacco and alcohol taxes are always the easy way out by penalizing the addictions that contribute to greater disease and disabilities. The fairest way to assist the uninsured is to gain resources from those entities that are reaping the extreme profits in our present system; that is, the health insurance companies that pay their CEOs huge bonuses (as United Health Care's 1.6 Billion bonus for one year). Think how much that amount would help. The other entities are the pharmaceutical companies. Any companies of these two entities licensed to do business in this state should contribute 10% of their gross toward funding care of the uninsured. Private health insurance companies will be out of business once national health insurance becomes a reality, and pharmaceutical company profits will surely be limited. If these two entities wake-up to this fact and pitch in to make our present work fairly for everyone, then funded preventative care in the long run will make a healthier America. • No matter what is done, tax dollars will carry the burden of any program. The amounts contributed by individuals and small business will be in most cases will not cover the cost of insurance. An assessment fee on items that impact health would be a large list. Tobacco, alcohol and fast food could top the list. It is not a bad idea to tax risky behavior. I think the risk factors for each would have to be established and graduated, i.e.: is smoking more of a hazard than fast food? Would that create enforcement problems? Is this question in reference to establishing more administrative offices for establishment and oversight of programs? Or how much should be spent hiring consultants to tell us how much of a problem there is? The state should hold down cost as much as possible. I think that once a reasonable contribution for insurance programs from individuals and employers is determined, we will have an estimate on the short fall that needs to be supported by the state. The current budget for Medicaid is not enough to offer the kind of health coverage everyone would like to see. Will the small business insurance plan/coop/program be enlarged to cover the 300,000 or so currently requiring services? • In part, what is an "appropriate amount" for Kansas to spend in tax dollars to provide all Kansans health insurance depends upon how big a fraction of a "typical person's insurance costs" will be paid by the state tax dollar as it is being collected today, and in part by new tax dollars collected just for this project. Realistically speaking, given the amount of money we are discussing, even with both the individual and employer paying most costs, a LOT more than the already heavily taxed tobacco sin taxes are needed here. WE need a "JUNK FOOD TAX" to fund this. Weight problems are also almost a "medical sin'. Almost everything but vegetables, fruit, meat, skim dairy products, and some breads could be taxed as "Junk food' -- a whole new revenue stream. This won't put a burden on businesses, the scanners in stores could figure the tax. 20% employer, 20% state, 60% person pays unless person or agency poor and get help from state.

	• It is difficult to know how much to fund until you decide what the package is going to consist of. If services and mandates were reduced, it may be possible to cover most people simply from the savings. Alcohol should be tagged as a major revenue source. The same arguments made for taxing tobacco are applicable to alcohol, and I suspect the social costs of alcohol far exceed those of tobacco, particularly in the under 40 age group. • I believe it is all of the above when you talk about containing the cost of health care. A. Health care reform- encouraging more healthy lifestyles, preventative care, care for the young and the elderly, etc. B. Insurance reform- Can anyone out there really compare one insurance policy to another? Confusion reigns with the providers and with the policy purchasers. Solution is to consolidate insurance coverage's into several packages that can be compared in a realistic fashion, both time and cost involved in the comparison. C. Providers should be paid in a timely fashion. With the electronic age and the ability to transfer money with the punch of a key, why does it take 30-45 days for pharmacies to be paid for claims and up to 180 or more days for other providers to be paid? As a pharmacist, I adjudicate claims in real time. The prescription benefits manager (PBM) determines my cost, my markup, the total price and the co-pay for my patient. This happens in about 3 seconds when the internet is running well. In my estimation money should be available to my account in 48 hours, just as a transaction with Visa or MasterCard. Drs., hospitals, etc do not bill in real time, but the knowledge and technology is present to make that happen. Turning ones money faster decreases the cost of doing business, thus in turn decreases the cost to the health care umbrella. One must look at the system as a whole, and not be focused on whether to include pregnancies, ED drugs, mental health coverage, etc. That particular thinking has led to the problems we are facing at the present. Changes are needed immediately, but changing the total package may not occur for many years, I hope I live long enough to see the fruits of our labors. Together we must pool everyone's ideas and come up with viable solutions. • Paying providers at the point of service is certainly admirable and looked forward to by the providers and patients as well. This is beginning to happen. It has a long way to go to get to every health care provider, but with the improvements in technology that are happening, this will occur. However, this will have a minor impact on health care costs. • The balance, whatever the amount, could come from three sources, separately and in combination. 1) "The Fund" compassionately contributed by private health insurance companies and pharmaceutical companies doing business in this state, 2) tobacco and alcohol companies doing business in this state, and 3) casinos doing business in this state. • I think we do a real disservice when we point too many fingers at the insurance carriers and plan administrators. They are certainly part of the equation and they must be considered, but to place too much blame on their backs is not fair or accurate. The payors are not trying to confuse providers or patients. While there are examples of wrongly denied charges, what doesn't get communicated is that a very high percentage of claims are handled appropriately. Plans are complex, difficult to administer and explain, but there isn't malice involved (again, with some highly publicized exceptions). If you get under the covers and look at claim administration,

	you will see that carriers handle insured plans -- those they are at financial risk on -- in the same fashion as they handle self-insured plans. And most carriers clearly want their plan members to take advantage of preventive services. It would be short sighted on their part to hope members hold down costs in the short term by avoiding all care and simply hope they go to another carrier when they have big claims.

Health Reform Framed Around Three Draft Messages

2. Paying for Prevention and Primary Care

	At-Large Council
Healthy Lifestyles	• No responses were given by the at-large council with regards to this question.
Interventions	• It should be easier, theoretically, to prevent smoking than to stop it. I did research on the subject 20-30 years ago. I also tried to help an agency that I directed, employing many alcohol counselors, to work on smoking issues. I got exactly nowhere. I am convinced it is the hardest substance abuse problem to treat, harder than "hard" drugs like heroin and cocaine.
Health Benefit Designs to Incentivize and Reward Health	• No responses were given by the at-large council with regards to this question
Decrease Obesity and Tobacco Use	• If obesity is a strong concern, what better reason, than to introduce a new "SIN TAX" on bad eating habits-- in other words, on JUNK FOOD. You also gain a new tax funding stream to help pay for health care. In the long run, schools are the answer, with stress on sports. Tobacco, I believe, is already heavily taxed. Smoking is also increasingly discouraged in most places. I don't know what more can be done. If you show yourself to be a safe driver over a period of time, your car insurance drops slightly. Once you reach "goal weight" in weight watchers, you don't have to pay. Maybe if you stay at standard weight for your height for a year you should get a healthy lifestyle reduction in your premiums. Same for not smoking. • I think early education and intervention works best for prevention of obesity and tobacco use. School nurses could call in kids who show signs of obesity and get the parents involved in programs to get the kids more fit and into a lifetime habit of exercise. Nutritional education, removal of junk food vending machines, etc., could make a difference. • As there are now required sex education courses in school and teenage pregnancies may be decreasing, so there should be required

	health education classes that stress the proper foods to be eaten and abstinence from smoking. The only foods and drinks allowed on school property would be appropriate health foods and drinks. The sale of unhealthy foods and drinks to minors in a certain area near the schools should be forbidden. In regards to smoking, I have seen high school students smoking just off school property, within 100 yards to the entrance to the high school. Smoking should be illegal for minors no matter where the location as alcohol is now. The bottom line is that the best and most efficient information to give to children today is in the school system. Those that are home schooled should have similar requirements. The obese students today should be guided by school nurses to undergo rigorous but safe eating and exercise diets to reach realistic goals of weight loss and physical fitness. Awards to improve self-esteem should be given to those who succeed. Time and again, preventative measures while young will go a long way in ensuring a healthier adult and a less costly healthcare system. • Obesity is a complex problem with multi-determinants. I think the psycho-social-economic roots of obesity are often overlooked. When I shop at the Wal-Mart in Topeka at Wanamaker and Huntoon I am surrounded by many individuals who struggle with obesity. When I visit the Wal-Mart in Overland Park at Metcalf and 119th - most shoppers are trim and fit - this reflects the impact of socioeconomic status on obesity. From a psychological point of view I believe that obesity reflects the absence of Hope. For most Americans at the lower end of the socioeconomic ladder the American dream no longer exists or is no longer within their grasp. The American dream entails a good paying job, private ownership of a home, a nice car in the driveway, affordable health care, putting one's children through college, and a good pension. In the absence of being able to pursue the American dream - people eat and gain weight - it is a way to self-medicate an underlying malaise or depression with food. Obesity is not just a medical problem - but a psycho-social-economic problem as well. Until these other root causes of obesity are addressed - obesity will continue to flourish.
9/18/2007	• Other than immunization, smoking cessation is the most cost-effective prevention intervention for adults. Leading authority on guidelines and cost-effectiveness analysis, David Eddy, M.D., has referred to smoking cessation as the "gold standard" in prevention interventions. Dr. Tim McAffee, from Group Health Puget Sound in Washington State, called cessation services "the health care bargain of the millennium" in testimony before the Congressional Subcommittee on Public Health and Safety. Given the benefits of such services, the quality and success of Smoking cessation programs in Kansas seems to vary widely in terms of both availability and efficacy. Insurance coverage for these programs is spotty, and in most cases inadequate. We need to support and reimburse quality programs that achieve long term results. Tobacco addiction is a complex problem and current studies (See,, Nicotine Tob Res. 2004 Feb; 6(1):55-61; and, Archives of Internal Medicine. 2000; 160), show that smoking cessation programs that are tailored to the individual (combination therapies including counseling and the use of one or more pharmaceuticals) have a much greater success rate (up to three times better) than less sophisticated “one size fits all” programs that seem to be the norm. Therefore, it would seem worthwhile to consider offering smoking cessation as a carve out program to interested provider groups possessing the interest, expertise, and resources needed to deliver results driven multifaceted smoking cessation programs. This is

	the standard of care recognized by the AHRQ (Advance for Managers of Respiratory Care, 5/1/200; 10(5):41-45).
Health Benefit Designs to Manage Chronic Disease	• Keeping in mind, the overriding necessity to use limited resources wisely, it seems that we should take advantage of the experiences of our predecessors, and drop the idea of disease management programs. There is no credible evidence that these programs deliver any measurable benefits in terms of health outcomes or financial savings. In fact, a study conducted by the prestigious Mathmatica Policy Research, Inc., for CMS, concluded that there was no statistically significant improvement in health status of those patients enrolled in disease management programs compared to a control group. Furthermore, there was no documented financial benefit to the disease management programs. (Mathmatica Policy Research, Inc, The Evaluation of the Medicare Coordinated Care Demonstration: Findings for the First Two Years, March 21, 2007.) Recognizing the limitations of Disease Management Programs as well as the their considerable costs, perhaps it would be more effective to reimburse and support sub-specialists to engage midlevel providers for patient education, preventive care and facilitate approved guidelines for the selected chronic diseases. The reason that this would work better than the standard “Disease Management” programs, is that patients, as well as their physicians and midlevel providers would be integrated and working together towards the same commonly identified benchmarks. An additional benefit is that the midlevel providers that would be delivering the chronic disease care would come from the same familiar society and culture as the patient. This is widely recognized as a desirable condition in any health care environment. In other words patients are more likely to listen to, and trust these providers. This should result in higher compliance rates. • Annual physicals are one way to get at a follow-up/preventative type of mentality. I really don't care how we encourage/require communication between docs and patients about their heath care plan but unless we have a follow-up system between doctor and patient, we'll continue to have treatments (or the lack there of) that do not meet the actual need because there's no check and balance between what the doctor told the patient and what the patient discovered in trying to meet the discussed expectations. There needs to be printed hand outs from the Doc to the patient on what treatment is being prescribed and follow-up to see if it met the need (most people chalk it up to guess I must just need to suck it up and put up with it, besides which I don't have the money to go back for another visit that is too short and won't get me any further than I am.) There's a HUGE difference between accessing unneeded care and accessing appropriate care. More importantly, those of us participating in this forum are all the ones who care and want to make a difference, there's a ton of people out there who are not above average students, e.g. care recipients. They do not have the knowledge or the skills to advocate for themselves. We'll have to be able to offer a free annual check-up and cheaper medication in order to get people to even consider buying health care insurance, especially if all they make is $5.50/hour!
Patient-Centered Medical Home	• No responses were given by the at-large council with regards to this question.
Prevention Efforts – State’s	• Barriers are generally the false psychological belief that "I will never get sick, for my body is impervious to disease". Then when that body's illness reaches a level of severe need for care, the remedy is beyond primary care, and, therefore more costly and will

Limited Resources	probably take the individual out of the workforce temporarily or permanently. This will only add to the cost of healthcare and be charged to the rest of us. To help remedy this, encouragement needs to be significantly issued in the form of tax benefits to those that routinely either yearly or semi-yearly receive good thorough exams to try to catch the hypertensive's and diabetics early-on, thereby rendering more lower cost-efficient care. This early care will hopefully keep the individual in the workforce and the charge to us would either be less or none at all. Now to encourage our healthcare workers to do this may take other financial incentives as tax breaks and deductive costs for their overheads. The other barrier is the cost itself to the individual to seek regular check-ups, the actual cost of the medical office visit and work-loss hours... the former is solved with the above suggestion and the latter (work-loss hours) can be solved by giving employers an incentive, such as providing "temps" while the employee is away receiving the physical care and possible short term treatment, since the disease was hopefully caught in time. Another incentive to the employer would be tax breaks for them for enlisting into this program.

Health Reform Framed Around Three Draft Messages

3. Promoting Personal Responsibility

	At-Large Council
Personal Responsibility	• Financial incentives are the best, by lowering cost of insurance or in the reverse, increasing premiums based on lifestyle. The latter would be the easiest to enforce. But, with this comes the question of "genetics". Should one pay more because they are African-American, Native American, or of Asian descent due to the increased chance of diabetes. Should Caucasians pay more since they are more prone to skin cancer? If your parents are obese and this is part of your family tree should you pay more premiums since you are overweight? I could go on and on. We are looking for viable solutions to the health care problem. Ones that can be implemented the easiest and where saving to the consumer are realized the quickest and at the same time increasing the level of health care that can be provided. Once the easy things are done then, tackling the personal responsibility of health care can be attacked. I am sure that starting at personal responsibility would be a financial bonanza for the legal profession. The number of lawsuits that could erupt would be astronomical. Imagine the lawyer arguing than Gertrude is fat because Mom and Dad were fat and that she comes from a long line of stout Germans that immigrated in 1899. We could spend the next decade just trying to define guidelines for fat, for hypertension prevention, prevention of strokes etc. Then you have to define disabilities. Does a person have a choice when they are born with cerebral palsy or Downs syndrome? The "what ifs and "coulda, shoulda beens" are never ending. The solution is consolidating insurance coverage to 3-5 basic coverage's that all insurance companies must sell. Group coverage must be eliminated and all policy holders placed in one large pool. By the insurance industry model, this would decrease their costs, (the larger the pool, the less risk for the company, and the lower the premiums.) Finally, the Federal government provides a stop loss for the insurance companies when catastrophic coverage is needed. The insurance company presents evidence that they are paying claims for an individual who fits the catastrophic coverage criteria and the government reimburses the insurance company. • Preventive medicine classically is the best form of medicine and the best and least costly for the consumer. Getting the Kansan to a

	doctor needs persuasion through the pocketbook where the individual has the greatest sensitivity. To gain that persuasion, provide tax incentives up to $500.00 per year per individual in the household upon proof of a yearly physical given by a physician or nurse practitioner where besides other worthy disease evaluations, hypertension and diabetes mellitus are tested. Another approach, which I feel is equally worthy if not more so, is to enlist the licensed health insurance companies in this state to provide full coverage for yearly physicals as stated above without a deduction. This would ultimately save the insurance companies money again by catching the disease early, simpler and less costly treatment, less payout and more profit (God forbid!) for the stockholder. Everyone wins. For those without insurance, we thinkers need to be more creative to give better incentives to get them insured. The tax deduction is one way, as stated above, but, another way would be for Kansas licensed health insurance companies to be required to provide menus of coverage comparable to those afforded by the present insured at a premium no more than say 9% of their gross annual income. Again, the yearly onetime physical cost would be free. Finally, to cover those who refuse to be covered, I see only two alternatives. Let them live in a truly socialistic state where everything is given them, or challenge them by a gradual increasing surcharge to their yearly income tax until they get on board with the rest of us. • An 8/27/07 op-ed column by Paul Krugman was posted here. • I love using the education analogy, as I believe that education and healthcare are "black holes" that could consume every resource you could generate, and you still might not get what everyone wants out of it. I would not disagree that each child is entitled to a high school education if they want it. But we don't guarantee a college education, even though the child would be far better off financially if they had it (and chose to use it). Should healthcare likewise be an entitlement for those who chose to seek it? But again in this instance, why guarantee beyond the equivalent of a high school education when it comes to healthcare? Let's guarantee everyone a Cadillac instead of a VW bug! At some point we have to look at what is the appropriate level of personal responsibility? If people are eligible for assistance programs due to their income, and they choose to not sign up, why should we give them that college level healthcare? We can always add tax onto tobacco, fat folks, ugly folks, gamblers and drinkers. Where do you stop? Give everyone a fair shake for a fair price- if they want more they can buy it. If they can't buy it, then let the government decide who gets it (ala Medicare). • I would agree with this column whole-heartedly. The children are our future and the elderly our history. It does seem ironic that a child can go to school sick, because Mom and Dad cannot afford health insurance or even if they have it, they may not be able to afford an office call or they may have enough health care debt already that they are a little antsy about adding to it. • My youngest sister and her husband had limited income, not enough to afford health insurance but too much to be eligible for public coverage. Since she couldn't afford doctor visits, she got allergy medication through a friend's prescriptions. She had not visited a doctor in ten years for med review, titration, better medication more suited to her condition perhaps. In l9995 she had an asthma attack on a New York City bus, was carried out to the sidewalk where she died while waiting for an ambulance. There are 47 million people uninsured in the U.S., many in my sister's predicament, no doubt.